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# PITFALLS OF OPHTHALMOLOGY

BY

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*Case I. Dimness of vision.*—Recently a young Mohammedan girl aged about 15 or 16 years came to me complaining that she could not see with one eye for about a fortnight. It was found on examination that her vision was restricted to finger counting at 1 foot and not completely blind. I was nearly making up my mind that she was hysterical. The unilateral affection of the eye and the absence of any sensory disturbance on that side made me examine her ocular condition in greater detail. Retinoscopy showed she had a unilateral compound myopic astigmatisim of six dioptres in one meridian and ten in the other. The glass correction improved her sight a great deal enabling her to count fingers at 25 feet and not more—evidently a case of amblyopia in one eye with no change in the fundus. It would easily have become a matter of ridicule if after a wrong diagnosis of hysteria by me she had improved her eye sight with an indifferent correction of refraction by a common optician. On the contrary a functional disorder wrongly diagnosed as an organic disease and treated ineffectually is equally a serious pitfall in ophthalmic practice.

*Case II. Hysterical blindness.*—A boy aged 18 years said to be blind for six months was brought to me having been previously treated in vain with iodides, setons, blisters and Salvarsan injections etc.. The pointed gaze of the patient at fingers shown from a long distance though refusing to count them made me certain that it was a case of unconscious imagination. Finding no change in the fundus and pupillary reactions, I stamped hard on his feet which were probably low in sensibility. The palpebral fissures widened, the mouth gaped, and he started counting fingers straightaway and with stronger and stronger pressure of my foot the enfeebled sight was quickly restored in steady steps from 6/60— 6/6 !

*Case III. Malingering.*—It is hard to say the difference between malingering and hysteria. A few days ago an unmarried girl aged 18 years came to me complaining of blindness in one eye as a result of the fall of a child on her face while playing with it. She was accompanied by very near and sympathetic relatives who all joined with her in saying that she was blind in one eye. I soon found out by usual tests she was simulating blindness. On careful enquiry I found the need for the intentional deception was a proposed marriage which the patient did not like.

*Oedema* of the lid often causes more alarm to the patient than the lesions which lie behind it. False diagnosis in oedema may cause the patient great anxiety for perhaps a very insignificant affection. A Desmarre's elevator is all that is necessary to prevent a serious pitfall and to show a normal eyeball freely moving and not proptosed beneath the lids. Inflammatory oedemas are caused by a hardeolum near the lid margin, acute dacrocystitis if the indurated and sensitive spot occupies the inner angle of the eye, commencing abscess of the lids, periostitis of the orbital margin, erysipelas, angioneurosis of the lids, eczema and trauma. Diphtheritic conjunctivitis, severe Iridocyclitis, or Panophthalmitis may be revealed on opening the oedematous or closed lids. Non-inflammatory oedemas are caused by heart disease, hydraemic nephritis etc., requiring a general examination.

A variety of oedema which can be called neither inflammatory nor non-inflammatory is the one associated with blepharospasm that has lasted a long time in cases of phlyctenular conjunctivitis in children. The oedema is confined mostly to the upper eyelid and is due to the compression of the palpebral veins by the contracting musculus orbicularis.

In the above mentioned conditions the vision is not impaired and the eyeball is normal.

*Keratomalacia.*—Is a condition where an early diagnosis of the real state of affairs would help to avert a serious irreparable damage to the eyes. People bringing these children are not alive to the seriousness of the general condition which they have neglected for days together. It is usual to see these children brought for the treatment of a small pit in the cornea. On closer examination a xerosed conjunctiva, and perhaps a hypopion appearing as a small horizontal streak at the bottom of the anterior chamber is seen. The necrosis is independent of any superficial microbic invasion. A general examination which should never be omitted in such cases reveals a marasmic child with swollen, shining tough abdomen with distended veins, the chest and limbs quite ricketty, face often monkey-like, the skin thrown into folds, a

child aged two or three years looking like a baby of few months old. The liver may be enlarged, jaundice with diarrhoea and offensive micturition may be present; the child practically in a moribund state. The same evening, or the day following or within a few days the whole cornea is necrosed and a keratocele forms. Soon the keratocele bursts exposing the iris, the eye is lost and ultimately shrinks.

An early diagnosis of this dire malady is easily made in all cases that come with a complaint of night blindness. In the early stages the conjunctiva has a characteristic lack-lustre appearance with a transparent white foamy patch on either side of the cornea. The fatty character of the epithelial surface gives the dry appearance to the conjunctiva and cornea though the eye wells with tears. Bandaging of such eyes does not prevent the dryness as in the case of Neuroparalytic Keratitis or Keratitis with logophthalmos.

*Treatment.*—As soon as you see the early dryness of the eye put the child on raw unadulterated milk from cows fed preferably on green fodder undeterred by the bowel symptoms that may be present, and by the statement of parents that the child does not tolerate milk and by not venturing to use boiled milk considering the urgency of energetic and effective treatment during the first few days of the illness. A liberal amount of fruit juice, thyroid extract, administration of sufficient amount of salts like chlorides of sodium, calcium and ammonium, attention to personal hygiene, warmth and protection as essential for the local treatment of eyes go a good way in alleviating the keratomalacic babies. The improvement in good many cases after this regime of treatment gives the lie to the grave pessimistic prognosis given in our text books on this disease. This has to be strongly deprecated considering the good that can be done to most of these cases by giving them at least moving sight in their later life provided the condition is diagnosed early and active measures instituted from the very beginning.

*Trachoma.*—Another common pitfall is the diagnosis of Trachoma which is becoming more and more difficult nowadays, even for the experienced trachomologist. In this connection it is worth recapitulating the disposition of the vascular system at the limbus. The vessels at the margin of cornea and limbus are divided into three distinct zones. The most peripheral zone called the palisade zone is 1 mm. in width and consists of elongated vessels. Next, the zone of vascular loops about 0·3 mm. in width is a net work of anastomosis. Finally, nearest the clear cornea with a distinct transparent margin is the very narrow zone of end capillary loops, from which the cornea is nourished by exudation of lymph.

The vascularisation of this clear corneal tissue as seen by a slit lamp is characteristic of trachoma even at its very inception. Anastomosing loops are found in clear cornea in many conditions. But the presence of non-anastomosing vessels alone differentiates trachomatous pannus from a severe case of advanced limbus.

There are besides, grey elevations or infiltrations characteristic of trachomatous pannus. Thus the so called pannus that is seen with the naked eye in some cases of granular ophthalmia as a complication is present in every case of trachoma from the very beginning if seen with a corneal microscope.

The vessels in interstitial keratitis cannot be traced from cornea to conjunctiva. They always stop short at the corneal margin. The presence of follicles of a non-specific nature are so common in the lower fornix that only a careful biomicroscopic examination of the follicles with the detection of pannus at the limbus can justify a diagnosis of trachoma.

*Superficial Punctate Keratitis.*—This is commonly mistaken for Trachoma and here again the slit lamp comes to our aid. The detection of curd-like deposits and absence of pannus in the cornea settles the diagnosis in favour of S. P. K.. This is necessary as treatment on mistaken lines often leads to disastrous result.

*Spring Catarrh.*—This disease is getting more common nawadays, and should be easily diagnosed from the history of allergic tendencies in the patient, the typical naked eye appearances of the follicles, the presence of esonophile cells in the follicles and the absence of pannus. In my experience in almost every case of spring catarrh the cornea is studded with dots as in S. P. K.. Not infrequently trachoma and spring catarrh co-exist in the same case.

*Case IV. Heart Disease and papillury hypertrophy.*—Years ago I was treating the lids of a Mohammedan boy for Trachoma. The papillary hypertrophy continued unabated in spite of the various methods of treatment usually adopted for trachoma. To day I would not be harassing the patient as a case of granular ophthalmia as the slit lamp would have revealed the absence of pannus. The peculiar lividity of conjunctiva like a goose skin, and cyanosed general appearance drew my attention to the heart rather late. The boy had congenital heart disease. In this case the passive congestion due to the presence of a patent foramen ovale was the cause of trachomatous-like papillary hypertrophy.

*Parenands' conjunctivitis*—May be mistaken for trachoma with acute onset The monocular nature, presence of pyrexia and enlargement of preauricular and submaxillary glands, freedom from corneal complications and absence of sequlae under observation from a few weeks to few months characterise the disease.

*Follicular Catarrh.*—This may be said to be a total property of the opthalmologists is the toxic type caused by atropine, eserene scopolamic and nothing to do with the purity of the drug, sterelity of the solution or the ptt of the solvent and only to be accounted for by the idiosyncrazy of the patient. Inotation of the eye is heightened by $Agno_8$.

*Recurrent Pterygium.*—Never remove a recurrent pterygium *ie.*, the one recurring after excision or transplantation.

In one of my cases of recurrent Pterygium, when I removed the apex of the Pterygium and the adjacent portion which had to be snipped with scissors the sclerotic showed a black slit with escape of vitreous evidently through the epithelial invagination which has taken place after the first operation.

The solution of continuity of the corneal epithelium which takes place after removing the apex of the pterygium from the cornea, probably gives rise to an in-dipping of the surface epithelium which grows back through the sclerotic and subsequently lines the vitreous chamber. This is my own explanation analogous to anterior chamber cyst formation after cataract operation causing uncurable glaucoma.

*Acute Dacryocystitis.*—Opening of the abscess cavity behind instead of in front is a rare complication causing orbital cellulitis and secondary optic atrophy. Orbital cellulitis from other causes like infection of the posterior ethmoidal cells as occurring in children never mars the intergrity of the optic nerve, at any rate in my experience. I have seen two instances where optic atrophy supervened an attack of acute Dacryocystitis bursting behind into the orbital cavity. Both of these were in obese woman about 35 years old. It was only after the cure of the orbitual cellulitis the orginal chronic dacryocystitis became evident. In one case the eye was already blind when I saw the patient with well established orbital cellulitis In the other I opened the acute dacryocystitis, not with much success, and the cellulitis travelled behind causing proptosis and immobility of the eye. In this case multiple incisions were made and the cavity was emptied by driving in a sinus forceps to the apex of the orbit. This procedure though it cured the cellulitis follow-

ing the perforation of the posterior wall of the sac was of no avail to avert the gradual onset of atrophy of the optic nerve which was complete by the time the phlegmen was cured.

I was helpless and it was heart-rending to see the pupil getting slowly dilated and inactive while the optic nerve was losing its pink colour giving place to china whiteness during the course of the treatment. I have included these two cases under the heading of my subject to-day just to show how impossible it is to avert the serious calamity to the optic nerve in these rare cases where the sac burst posteriorly or the inflammation travels behind according to the chronic or acute nature of the infection. The history of one-sided epiphora and chronic discharge from the angle of the eye in these cases makes us feel certain about the aetiology of the condition.

*Hypopion ulcers.*—In this affection the patients usually give a history of a thorn prick, an injury with a leaf or the angle of a cloth, an insect bite or a scratch with finger nails. Dacryocystitis is very often the underlying cause and one must not be misguided by the history which in some cases is only a predisposing cause.

*Operation of or the Removal of Lachrymal Sac.*—For detection of the sac the white shining apponeurosis anterior to the sac forms a good land mark, and this must always be worked for as otherwise a wrong incision and careless procedure would lead to the removal of orbital fat as the lachrymal sac.

*Headache.*—There is no symptom like headache which the physician is called upon to treat that may not be due to or influenced by symptoms of eye strain. Eye stress very often affects the vegetative nervous system in susceptible individuals. Hence when the autonomous nervous system is interfered with the basic functioning of circulation and cellular innervation are disturbed and a regular ' Pandora's box ' of troubles may be opened.

Disturbances of vegetative nervous system are caused by many other factors affecting adversely the various parts of the body. Hence most of the symptoms ascribed to the eye strain are seen in the domain of every branch of medical specialists, thus for instance, the symptom of headache, dimness of vision, pain in the neck and shoulder often running down to finger tips with numbness, tingling and parasthesia are manifestations of eye strain. But this can be claimed by Sinusologists as Sludder's Syndrome, by Urologists as kinks in the ureter, by internists as indications of focal infection, by cardiologists as effort Syndrome and probably by Podologists as a sign of fallen arches. And as such headache is a symptom round which all medical

men, general practitioners and specialists should rally, co-operate and relieve the patient of his suffering.

Headache may be classified as

(*i*) originating from the eye.

(*ii*) not originating from the eyes

Even the most experienced medical men may sometimes make the mistake of treating headache as a symptom of minor significance when it really may be the first and the earliest symptom of some grave impending organic disease. About 10 per cent of all cases of headache are of ocular origin. The results of eye strain are obvious in many cases, but I am convinced that we will often be in error in concentrating all the attention on the eyes and the error of refraction, without paying due attention to the patient's general health. Big errors go without symptoms of eye strain while small errors cause great systemic disturbance. It so happens while correcting big errors of refraction, a residual astigmatism may be left uncorrected with the result that the patient is made alive to the headache and annoyance of eyestrain for the first time because his large error has been almost but not quite corrected leaving him with a small error.

The contrary that all small errors must be corrected is certainly wrong unless there is an incriminating symptom associated with a small error. No eye is perfect and I learnt recently that a—0.25 cyl. horizontal or + 0 25 cyl. vertical is necessary for many eyes though the ametropia is very often symptomless.

In bifocal glasses want of correspondence of optic centre of glass and optic axis of the eye is a common cause of headache even after a meticulously done correction by an ophthalmic surgeon.

A loose circular frame gives rise to the change of axis of the glass while cleaning and consequently the glasses loses its effect if it is a simple or compound cylinder by a change of its axis and thus causes headache. This difficulty may be obviated by fitting the glass in an oval frame or prescribing a rimless glass.

*Muscle imbalance.*—This is another cause of headache. Very rarely any investigation is made to find out latent fault in muscle balance, latent, in the same way as latent hypermetropia. Such latent errors cannot be easily detected as there is no myoplegic analagous to cyclopegic available to throw the extrinsic muscles out of gear and relax them. Resort must therefore be had

to prolonged occlusion tests, *i.e.*, to occlude one eye making binocular vision impossible for a sufficiently long time so as to abolish all spasm of the extrinsic muscles of the eye. By these tests any deviating tendency of the eye is made evident. If it be admitted that a latent deviation involves an enormous expenditure of energy and therefore brings on a condition of muscle exhaustion or fatigue then it is easy to understand how an eye with muscle imbalance can produce a headache. Absence of such a condition must be shown conclusively by adequately carried out occlusion tests or other means before acquitting the eye as the cause of headache.

Cases with muscle imbalance go on without any relief whatsoever after several examinations and prescriptions from several eye surgeons and even after wearing accurately corrected lenses. The symptoms of imbalance are photophobia worse after reading, while reading brings about soreness of the lids and if persisted in acute pain. If reading is still further persisted in, pain in the eye-ball, blurring of vision and acute occipital headache ensue.

*Treatment.*—After a week's occlusion latent deviation may become manifest as exophoria, esophoria or hyperphoria of different degrees, which may be corrected by prescribing accurately calculated accepted prisms. The patient is finally relieved and finds to his disgust how useless were his different pilgrimages to various specialists.

*Glaucoma.*—Though the headache in this affection is associated with inflammation, weeping, photophobia, pain and tenderness, these signs may actually be absent at the moment of examination of a glaucomatous eye—a bigger pitfall in diagnosis there is yet to be for a general practitioner, or for that matter a specialist.

In prodromal Glaucoma pain is in the after-noon or evening with sleep. Patient never wakes up with headache. Excitement such as the death of a dear relation, business crises bring on the increased tension. The signs of Glaucoma need not be enumerated here, but the mistakes which many practitioners of medicine commit is the wrong diagnosis of cataract for Glaucoma and asking the patient to wait till his vision reduces completely believing the condition to be an immature cataract that should take time to mature. Such a mistaken diagnosis and advice inevitably results in incurable blindness while an early and a correct diagnosis hold every prospect of retaining useful if not good vision.

Every physician has an opthalmoscope in his armamentarium, and when he can with ease diagnose the finer changes in the retina in certain

constitutional conditions like hyperpiesia, or renal retinitis, would it be too much of an appeal to request him to examine the anterior segment of the eye to detect the presence of any lenticular change which is the easiest to accomplish and at least to refer patients to those working in this speciality when they find no lenticular change yet headache and failing sight ?

Though it may be difficult to diagnose glaucoma yet it is easy to see if the lens is clear and easier still to advise what to do, thereby lending the ophthalmologist a helping hand in reducing ocular mortality.

Headaches not orginating from the eyes :

Migraine, frontal sinusitis supra orbital neuralgia though causing headache have distinguishing characters. Very often a patient with chronic nephritis goes first to the ophthalmologist for his headache the severity of which depends upon the intensity of uraenic intoxication. In good many of these cases the sight may be normal although the changes in the retina and optic nerve are sometimes so characteristic as to draw one's attention to examine the urine to find it loaded with albumin.

*Pregnancy.*—Headache during pregnancy may mean rise of blood pressure. And with vomiting and nausea if retinal haemorrhage takes place threatening to damage the sight, the question of induction of abortion must be seriously considered.

*Pituitary headache.*—This form of headache with more frequent eye symptoms occasionally come for treatment. Pituitary headache occurs usually in adoloscent women and is charactered by,

(*i*) Its location—Frontal and deep behind the eyes.

(*ii*) Its characteristic radiation.

(*iii*) Duration of persistence.

In the female it comes on with the periods which is usually profuse soon followed by nausea and vomiting. Marked fatigue characterise the pain in the head. Patient develops periodic craving for sweets, indulgence in which increases the headache, polyuria and signs of dyspituitrisim.

Contraction of temporal fields, primary optic atrophy, enlarged sella-turcica, failure to respond to treatment, all mean a progressive neoplastic growth. ½ to 2 grains of whole pituitary gland may be of use.

*Cinema strain.*—Seen more among the poorer classes induced by prolonged observation of pictures and other objects at a level much above the observer who often sits in the front pit near the screen. Hence, the proximity of the seats to the screen and the height of the screen are matters of importance. Angle of elevation should not exceed 35°. There is no use of prescribing low correction in these cases without going into the history of the cause of headache.

*Disappointments after operation.*—In a woman aged 30 years after an attack of small pox, I had to do an iridectomy for optical purposes in both eyes Preliminary examination showed a good prognosis for giving useful sight and no contraindication was apparent. An iridectomy was done, the coloboma was fine and black, but the optical result after the operation was nil. I was disappointed.—But on careful examination of the coloboma with a powerful illumination, I found out that the retinal pigment layer of the iris was adherent to the anterior capsule of the lens, and it was impossible for the light to pass through. In this case there was nothing left but to extract the lens though the lens was perfectly transparent. Both the lenses were extracted, with good optical result more than compensating the first disappointment.

*Accidents after operation*—Expulsive haemorrhage. This is very often due to the degeneration of the vessels of the eye. In the absence of a hard eye, increased ocular tension or other general disturbances of metabolism like, diabetes, albuminuria—the mere opening of the anterior chamber with consequent sudden reduction of intra-ocular tension is enough to cause an expulsive haemorrhage.

Such accidents are invariably prone to occur in big fatty women, and I invariably put such patients on anti-haemorrhagic remedies before I do an extraction of the lens for cataracts. It was mentioned by some experienced ophthalmologist in of one of the sessions of the All India Ophthalmological Society that if one eye is lost by expulsive haemorrhage one is quite justified in doing a Mohammedan operation in the other eye.

*Enucleation of the Eye-ball.*—Enucleation of the sound eye by mistake is the worst pitfall that an ophthalmic surgeon will ever meet with.

*Rare complication during enucleation.*—Enucleation is capable of causing sudden collapse of the patient, just as you cut the optic nerve. This happened to one of my cases years ago during the pre-local anaesthesia days.

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# MEDICAL INSPECTION OF SCHOOLS.

By

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## Object.

The late Dr. Annie Besant was never tired of repeating her favourite slogan " The young men of to day are the future citizens of to-morrow ". As we sow, so we reap. Neglect the physique of the child, you rear a nation of weaklings. Neglect the education of the child, you breed a race of ignoramuses. The lot of the majority of our children, is malnutrition, disease and ignorance. The problem of nutrition is vitally connected with the economic condition of the masses, and unless and until our men, women and children, have enough of the proximate principles of food with the necessary accessory food factors called vitamins, any amount of medical relief, medical inspection of school children, and even national health insurance, cannot even touch the fringe of the problem This is a fundamental problem to be tackled by those in authority and power. In my humble opinion, the best way of insuring the health of the nation, is by providing the necessary quantity and the proper quality of food for every human being in India. Where the problem of hunger is not solved, to think of national health insurance in its conventional significance, will be futile. In my opinion it would be sheer waste. Even medical inspection of school children, perfectly carried out by conscientious medical men, may discover some diseases and infirmities, but can never put enough rice, vegetables and milk into the stomachs of the children, whose parents cannot afford them. Having been a medical inspector of three secondary schools with an aggregate student population of more than one thousand, in a municipal town during the years 1925—31, I felt that the problem of adequate and proper food was of more vital importance, than the curing of some cases of phimosis, removing some tonsils and correcting some errors of refraction, though I do not minimise the importance of these therapeutic measures. I should earnestly urge on the authorities that simultaneously with the re-introduction of the system of medical inspection of school children, energetic efforts must be taken to improve the lot of the people. Otherwise the results of this important item of national health inspection will be barren. Properly conducted, this is a vital aspect of national health insurance and the medical profession in general, can play a great part. With the introduction of compulsory elementary education, we require the services of every medical practitioner to make the scheme a success. My past experience, as a medical inspector under the old system, has put me in a position to give the readers

some suggestions for careful consideration as to how to make the best out of the scheme Some of the suggestions may be revolutionary, but, if carefully considered by my readers and the authorities, will benefit a large body of general pracitioners, all over the presidency. In my belief, this scheme, will reach such an efficiency, that the children will get the full value for the money spent.

### Who should be Inspectors ?

So far as the villages are concerned, the village medical officers must *ip so facto,* become medical inspectors and should be entitled to the remuneration adumbrated by the scheme. As regards other schools in the bigger villages, towns and cities, the work must invariably be entrusted to general medical practitioners, who are not in receipt of any salary or honorarium from any source, Government or private. In the previous scheme in vogue between 1925—31, there was a rule that the management of schools should invariably go in for a salaried assistant surgeon in Government service. Though in good many instances, that rule was not followed by the management, it was fundamentally absurd I personally should like fair distribution of the remuneration among as many general practitioners as possible, irrespective of their educational qualifications, rather than pay the already paid.

### The number of Students for each Practitioner.

I should not entrust more than 400 students to each practitioner. In any case it should not exceed 500. If it exceeds 500, another medical officer should be appointed to work conjointly. In the case of such big schools as the Hindu High School, Triplicane, with a student population of more than two thousand, I should appoint five medical men to form a board, at the rate of one for 400 children. The board should have joint responsibility and the work can be divided among them, though the report for the school should be single, signed by the members of the Medical Board. Even in the case of Municipal or Corporation schools, the same procedure can be adopted. I certainly dislike the idea of a full-time medical inspector, doing the same monotonous thing, day-in and day-out, all the year round. Every medical man should have some variety and for a general practitioner, medical inpection, should be a pleasant variety.

### Who should appoint Medical Inspectors ?

Since the scheme will be a huge one, I should, with all the earnestness I can command, urge on the Government, to arm the South Indian Medical Union, at Madras and the different District Medical Associations, with power

to appoint medical men for this work, from among its members. I am sure the different medical associations, will be the most competent and authoritative bodies for this responsible work. Only medical unions will be in a position to know who the most deserving practitioners are and they can do the work by the system of rotation among the practitioners Every practitioner may legitimately wait for his turn and even the most uninfluential of the medical practitioners, may have justice done to him The medical associations can also take such of the practitioners to task, as do not discharge the duties properly. The Government, under this system, will be relieved of a good amount of routine work. And the medical associations also stand to gain in the shape of increased membership.

**How many examinations a year ?**

I should like two examinations in a year, say August and February. In special cases, repeated examinations may be necessary. Under the system of 1925—31, there was only one examination and I was not at all satisfied. To wait for one full year for following the progress of students, is utterly meaningless.

**How to carry out the recommendations ?**

The main point and purpose of medical examination of children is to discover disease processes at the earliest stage and recommend suitable preventive and curative treatment. In my experience of the system of 1925—31, I can boldly say, that it was a thorough failure, since the majority of students, who were reported upon, returned again and again, in successive years, with the same defects or diseases unrectified. I found, for example, some instances, where children with marked myopia with distance vision less than 6/60 being allowed to go on for years, in spite of the usual annual reminders from the medical Inspector. Not even five per cent. of the recommendations were carried out by the parents. There must be some method by which we must be able to bring pressure on the parents for such derilection of duty. Where, in the opinion of the Medical Inspector, or his consultant, the disease or defect, is of such a nature, as to be prejudicial to the physical well-being of the student, and where the parent or guardian, in spite of suitable reminders, does not move in the matter, the child should be suspended from the school, till such steps are taken. This measure must be reserved for extreme cases of negligence. But ordinarily, the parents must be first communicated with. Failing suitable action, he must be reminded and then interviewed by the Medical Inspector With some propaganda among the parents, much better results could be achieved. For cases requiring ordinary treatment, the family doctor of the student must be competent to manage.

Poor children may be referred to state and public hospitals. Where the case requires specialist treatment, the Medical Association can furnish a list of specialists, or institutions where such treatment can be obtained. For parents who can afford to pay for such specialist treatment, the Medical Association should only indicate who all, preferably in alphabetical order, are competent to treat, leaving the choice to the parent. This matter being very delicate, must be very carefully handled. Each case, and each disease must be judged on its own merits. Much fuss need not be made on a tiny hydrocele, but cases of marked error of refraction, hernia, bad phimosis, etc., must be treated as expeditiously as possible, For indigent students suffering from malnutrition, there must be provision for giving milk and cod liver oil free. This philanthropic work can be undertaken by voluntary charitable associations.

### Medical Inspection of Girls.

Should also be enforced. Where women doctors are not available men may be permitted to examine girls up to the age of 12. For girls of 12 and over the services of women doctors must be requisitioned.

### Teaching of Hygiene in Schools.

I am averse to include hygiene as a subject to be studied and passed by the students. When a subject becomes an examination subject, it becomes a bore. The fundamentals of hygiene must be compulsorily taught to the teachers handling the primary classes, who in turn, by example and precept, should inculcate hygienic principles in the students' early impressionble age. Instead of the medical inspectors themselves taking students, I should arrange for weekly lectures on hygiene to the elementary school teachers themselves. Once a fortnight the medical inspectors themselves can give magic lantern and Cinema film demonstrations on the principles of hygiene to students divided into three categories (1) Forms IV-V and VI (2) Forms I, II and III and (3) Classes III, IV and V. We can omit classes I and II.

### Physiology and First Aid.

I should have the students of IV or V Form to study elementary physiology and first aid compulsorily. It should be possible to give an elementary idea of the subject in the course of 15 weekly lectures.

### Remuneration for Medical Inspectors.

Under the scheme of 1925-31, Medical Inspectors received at the rate of 12 annas per pupil for the first inspection and 6 annas for the annual repeat

inspections. One-third of the cost was borne by the students, one-third by the management and the other third by the Government. I am for thoroughness of the examination whether it is the first or the repeat. So I should have a uniform scale of one rupee for each pupil in all the classes. In the case of secondary schools levying fees, eight annas may be collected annually, in two instalments of four annas each from the pupils, four annas may be paid by the management and the balance of four annas may be met by the Government. In the Schools, where compulsory free education is in vogue, the management may pay eight annas and the Government the balance of eight annas. Medical Inspectors getting this remuneration are responsible, not only for examination, advice etc., of the students, but also the teaching of hygiene to the teachers, and physiology and first aid for a selected form. In the case of poor children, falling sick, in the absence of the family doctor, if any, the Medical Inspector himself, must give free advice by even visiting the child in its house. The Medical Inspector must feel he is responsible for the health of the children entrusted to him.

### A permanent room for Medical Inspection.

At least every High school, with a strength exceeding 400, must have a fully equipped medical inspection room, well lighted and at least 20 feet long. If, in addition, a dark room can be provided for, well and good. In addition to the ordinary paraphernalia, a Medical Inspector would be well advised to have a torch and a fore-head lamp. The Everready Company have a fore-head lamp, fitted with dry cells, at a cost of Rs. 5—12—0 or so.

### Book of Instructions.

The Government must publish a book of instructions giving full details with illustrations. The examination must be standardised.

### Record of Examination.

Each student should have a case-record printed in thick paper which should last for 7 or 8 years. In addition the results must be recorded permanently in a book, like the admission register, with the results recorded horizontally against each student. Even if the case record is lost, the permanent record will be of use. The system of 1925-31 was defective in this respect.

### Conference of Medical Inspectors.

The Government must convene a conference of all the medical inspectors of the Presidencies or a representative section of them, annually, to study the various problems connected with the scheme. This will facilitate evolution of uniform standards in medical inspection.

# CORRESPONDENCE.

## Appointment of Honorary Medical Officers

SIR,

Presuming that the Government are going to appoint more honorary medical officers, in the immediate future, there are one or two points which deserve the attention of the authorities in appointing officers

Whether for teaching or non-teaching institutions, mere academic qualifications, Indian or foreign alone, should not be the creterion. Along with academic qualifications, practical experience for a period not less than five years as assistant to a surgeon or physician must be strictly enjoined. The honorary system will be discredited if young and junior men, in virtue of their academic qualifications alone, are appointed to responsible posts of physicians and surgeons. The art of medicine or surgery is learned and perfected by constant and continuous practice only. True, such anomalies exist in the paid medical services, but such a vicious system should not be introduced into the honorary system. In enlightened countries like England or America, straight appointments as honorary surgeon or physician, simply because the candidate is an M.D.,M.S., M R.C P., or F R.C.S., is unheard of. There, every one must work up from the bottom however high his academic qualifications to start with. The system of appointing junior I. M. S. men to fill responsible posts in the civil services, should never be copied in appointing honorary men For non-teaching institutions, experience alone should be the determining factor though experience with academic qualifications should be an especial recommendation. Where, in a district hospital, experienced men alone are available, in the absence of experienced men with academic qualifications, the Government should not hesitate, for some time to come, to appoint men with experience only.

In teaching institutions such posts should normally go to junior men with high academic qualifications who should gradually work up to the status of physicians and surgeons. In non-teaching institutions, it should be open to any medical practitioner of about five years standing irrespective of the qualifications L.M.P., M.B.B.S., L R.C.P., etc.

Clinical assistants must be open to all recently qualified men and women. In my opinion the term "Clinical assistant" may be abolished in favour of "Junior assistant physician or surgeon".

Normally the following must be the grades in the medical services :

Clinical Assistants—5 yrs.
Assistant Physicians or surgeons—5 yrs.
Physicians and Surgeons—afterwards.

So, at no distant date I should have a physician or a surgeon to have put in not less than 10 years' work in his subject : only then will heroic medical treatment and spectacular surgery give place to medicine and surgery based on science, art, judgment and wisdom.

E. S. G.

# JOURNAL OF SOUTH INDIAN MEDICINE

DECEMBER, 1937.

## THE ANTI-TUBERCULOSIS FUND.

We are very pleased to know that the public has been made aware of the urgent need for a campaign against tuberculosis in this country by the work which Her Excellency Lady Linlithgow has undertaken to collect funds for the purpose.

Judging by the prompt response to that call, it is apparent that the public has been aware of the havoc created by the disease and that it was only awaiting a lead. And from the little that we have heard, we are confident that under Her Excellency's whole-hearted and sincere lead, a serious effort will be made by the public to collect enough money to plan out and lay the foundation for the successful fight against this disease. It was only in the last number of this Journal that we endeavoured to point out the urgency of the problem and indicated some of the methods that may be adopted in the campaign. We are more than gratified to learn from published reports that those who are responsible for the working of the fund have more or less similar views. In this Presidency we are fortunate that we have in the present Surgeon-General with the Government an experienced officer who is very keen on seeing something useful and permanent done towards mitigating the evil.

In the plan that he has sketched, two items stand out prominently. One is the training of a large number of young doctors in the modern methods of diagnosis and treatment of tuberculosis. And the other is the establishment of well equipped clinics with X-ray plant etc. where the disease could be discovered in its very early and therefore the more easily curable stages. Though he does not say it, these clinics in virtue of the X-ray outfit could also undertake the ambulant treatment of a large number of cases with artificial pneumothorax. These clinics in the long run would prove to be not only centres of diagnosis and treatment, but also important media for the prevention of the disease.

But the scheme, even if it starts with the very modest ideal of having only one such clinic for each district would cost a deal of money. And a centre for each district will not even touch the outskirts of the problem. We therefore plead with the public to be generous in their response to the appeal. We would also earnestly appeal to the Medical profession to further the cause by propaganda among their patients and the general public with whom they have great opportunities of coming into contact to help the cause freely. It is as well to remember in this connection that it is not only the very rich that should be approached but also the humbler and less well-to-do. Even very small donations from the large mass of the public would aggregate to a striking figure.

We make this appeal with great confidence because we have in the present Surgeon-General, a person who has clear and definite views about what has to be done, and who is extremely anxious that every pie collected should be made to fetch the maximum benefit to the subscribing public. For, by subscribing to the fund, the public certainly renders a service of mercy to the tuberculosis patient and his family. Indirectly it is a premium towards insurance by which society protects itself from future disaster.

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## THE XIV ALL-INDIA MEDICAL CONFERENCE.

The All-India Medical Conference will very soon be meeting here. This is the first time since its inception that this Conference is being held in Madras. Though the Indian Medical Association established in Calcutta has been in existence for some years, its hold on the southern presidency has been negligible. It is slightly better in the other provinces. Distance between the Head-Quarters of the various provinces has been one of the chief difficulties. There are other reasons why the Association has not been more successful. Chief among them is the existence of various classes of registered medical practitioners, each of which has its own organization, and, the interests

of the various groups apparently are not always identical. Further, the conditions of medical relief and the detailed organization of the Medical department vary from province to province, so that the problems confronting the profession vary according to provinces. But in spite of these differences there are many problems which are common to most provinces. A central organization can therefore avoid much repetition of labour and can serve as the clearing house for the needs of the profession in the different provinces.

But if such an organization should grow and function usefully, it would soon be imperative for the profession to consider whether the present organization of the Indian Medical Association is the most suitable for the purpose, and also whether the headquarters of such an organization should not be more centrally located.

We believe that The Indian Medical Association is more or less patterned on the British Medical Association, and has similar aims. We hope the similarity would end there. The branches of the British Medical Association in this country are chiefly dominated by the European members who are mostly officers of the I.M.S. There is the possibility that the branches of the Indian Medical Association in the districts may be dominated by the civil surgeons or District Medical Officers, whether they be Indian or European members of the I M.S. or Provincial Medical Officers of the Government. This possibility is not remote. We hope that such a situation will not grow.

The Conference is meeting under peculiarly favourable conditions which assure its success. We sincerely hope that this success will be utilized to broadbase the organization on the willing co-operation of the majority of the practitioners in the country. In this hope we cordially welcome the Conference to this city and wish the members a pleasant time while they are engaged in the strenuous work.

# NOTICES.

Notice is hereby given that the subject for Dr. Joseph Benjamin Prize of the value, of Rs. 35 (rupees thirty-five only) for the year 1937 is PUERPERAL SEPSIS, its CAUSE, Symptoms, treatment and prevention; and for the Dr. P. S. Ramachandrier prize of the value of Rs. 25 (rupees twenty-five only) for the year 1937 is CHOLERA, its prevention, causes and symptoms and treatment.

1. All bonafide members of the Association can compete.

2. Intending competitors are requested to write papers from practical point and on lecture style and the same should not exceed 1,000 typed lines or their equivalent.

3. The papers should be sent to Dr. Jamiatram B. Desai, President, Gujrat Branch, All Indian Medical Licentiates' Association, 52, Pritamnagar, Ellis-Bridge, Ahmedabad so as to reach him on or before the 31st March, 38.

(Sd.) P. S. TRIVEDI,
*Secy. Gujrat Branch, Ahmedabad.*

## THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION.

" The Anniversary of the Tinnevelly District Medical Association has been provisionally fixed for celebration on the penultimate Saturday in January 1938. The exact date will be notified later on.

2. A Grand Medical Exhibition will be held consisting of Surgical Goods, Medical Appliances, Drugs, etc.

3. Firms who are interested are requested to kindly send in their Representatives with articles. Stalls are given Free.

4. All correspondence on the subject should be sent to the following address :—

SECRETARY,
THE TINNEVELLY DT. MEDICAL ASSOCIATION,
PALAMCOTTAH.

## ALL INDIA MEDICAL LICENTIATES' ASSOCIATION, BOMBAY 4.

DR. U. B. NARAYANRAO,
GENERAL SECRETARY.

*101, Girgaon Rd, Bombay. 4.*
*4th December, 1937.*

DEAR SIR,

Please publish the following in your esteemed issue at an early date and oblige.

" Dr. T. C. Basu Chaudhury, a Licentiate Medical Practitioner, Eye Surgeon from Agra, has been invited by Dr. P. Bailliart, Chairman of the of the International Association for prevention of Blindness, to attend the General Assembly of the Association to be held in Cairo this month in connection with the XVth International Ophthalmological Congress This is the first time in the History of the Congress that a member of the All India Medical Licentiates' Association has been invited to the Congress.

Dr. T. C Basu Chaudhury, has done some original research work in ' Trachoma ' and had submitted the same for their consideration together-with a report regarding " Blindness in India " a general survey of the same.

Dr. U. B. Narayanrao, the General Secretary, All India Medical Licentiates' Association, 101, Girgaon Rd, Bombay. 4. has sent the following Telegram to Her Excellency Lady Linlithgow, Delhi.

"The All India Medical Licentiates' Association with its 167 branches places its services in the noble cause initiated by your Excellency to eliminate the scourge of Tuberculosis in our country".

And in reply to the above he has received the following wire from Her Excellency.

" Much touched by kind wire many thanks for offer of services "

## ALL INDIA MEDICAL LICENTIATES' ASSOCIATION, BOMBAY. 4.

DR. U. B. NARAYANRAO,
GENERAL SECRETARY,

*101, Girgaum Road, Bombay. 4.*
*8th December, 1937.*

The SCIENTIFIC RESEARCH COMMITTEE of the All India Medical Licentiates' Association, has awarded a Scholarship of Rupees Two-Hundred to Dr. A. N. Roy, B.A., L.M.F., Clinical Pathologist of the " Indian

Institute for Medical Research" Calcutta, for working on "Cultivation of Malarial Parasites".

The SCIENTIFIC RESEARCH COMMITTEE of the All India Medical Licentiates' Association has also decided to award a Cash Prize of Rs. 100 (rupees one hundred) for the best article on "Tuberculosis in India" which should include a general survery of Tuberculosis laying more stress on 'Prevention'. The Essay should not be more than one thousand lines of foolscap paper size and should reach Dr. Murari Lal Sahib, Tikonia Kothi, Agra, latest by the 31st March 1938. Essays received after the date will not be examined. The best paper selected will be published in the Indian Medical Journal and the winner will be awarded a Certificate of Merit together with the Cash Prize. All the members of the All India Medical Licentiates' Association are eligible to compete. The following gentlemen have been selected to be the examiners of the papers:—

1. Dr. P. K. Sen, M.B., M.D, Ph D., T.D D etc. of Jadanpur Sanatorium, Bengal.

2. Dr. B. K. Sikand, M.B.B S, D.P.H., Organising Secretary, King George Thanksgiving (Anti-Tuberculosis) Fund, Delhi.

3. Dr. Murari Lal, L M.P. Late Lecturer of Pathology, Medical School, Agra.

4. Dr. U. B. Narayan Rao L.C.P. & S, Editor, Medical Digest & Indian Journal of Venereal Diseases & Member of the Medical Council, Bombay.

Any further communications on this subject may be addressed to the undersigned.

"PRASADPURA HOUSE"
*Agra.*

Sd. T. C. BASU CHAUDHURY,
*Secretary, Scientific Research Committee, A.I.M L. Association.*

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# DIETETIC TREATMENT OF SPRUE

The difficulties of diet in Sprue have now been met by Sprulac, a scientifically prepared high protein milk food, which has been made specially for the Hospital for Tropical Diseases, London (Trans. Roy. Soc. Trop. Med., Vol. XXV., No. 4).

## Sprulac

REGD

MILK FOOD FOR SPRUE PATIENTS

Sprulac being a portable, dry, sterile milk powder, of high vitamin content will be found of special value in the tropics and on board ship owing to its convenience and safety in use. It will particularly appeal to vegetarians and others who are intolerant of a meat or ordinary milk diet.

*Clinical samples, literature and any further information will be gladly sent on request.*

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# ASSOCIATION NOTES.

## THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION PALAMCOTTAH.

*(Tinnevelly Branch of the Indian Medical Association)*

The Tinnevelly District Medical Association held its monthly meeting on Saturday the 27th of November 1937, at the St. John's College Hall, Palamcottah Members numbering 55 including 3 women doctors gathered from all parts of the District.

After Tea and Sweet Music, the Meeting began under the Presidentship of Lieut. Col T. S. Shastry, I.M.S, at 6 p. m. The Secretary and Treasurer Dr. K. Rama Ayyar, M.B., B.S, (Andhra), read the minutes of the Joint Meeting held at Madura on the 23rd of October 1937. Then the President requested all the members of the Association to attend the XIV All-India Medical Conference at Madras, in as large numbers as possible. He announced about the ensuing Anniversary in January 1938.

Dr. Dutt, gave an interesting lecture on Vitamin C and its tests.

The following clinical cases were demonstrated :—

(1) Tubercular Joint (ankle).
(2) Tubercular femur and Abscess thigh.
(3) Stab Injury Chest exposing the lung.
(4) Appendicular Abscess.
(5) Cancer Thyroid—with metastasis in ribs and Tibia
(6) Fibro-Epulis upper right maxilla.

Dr. P. S Srinivasan, sub assistant surgeon attached to the Government Headquarters Hospital, Palamcottah, read case notes of the above cases and demonstrated the cases to the members.

The above cases and the lecture were fully discussed by the members In this connection the beneficial effect of treating tubercular sinuses and tuberculosis of other organs bv garlic and its juice was pointed out by many members It was considered that this drug is worth trying in all tubercular cases. Then the President brought the meeting to a close by his remarks on the subject of the lecturer and summed up the salient and important features of all the cases. He thanked the College Authorities for placing the College Hall at the disposal of the Tinnevelly District Medical Association for holding the meeting of the Association. He also thanked the musician Mr. Sankaralingam Ayyar, for his kind performance.

Thereafter an excellent Dinner brought the happy gathering to a close late at night.

HEALTH EXHIBITION.

Under the auspices of the Tinnevelly District Medical Association in connection with its monthly meeting at the Headquarters (Palamcottah), a Health exhibition was arranged at the Municipal Office, Palamcottah. on Saturday the 27th of November 1937, at 10 a.m. which was attended by a large number of men and women teachers, and about 100 boys and girls.

Lieut. Col T. R. Shastry, I M.S., explained in English the defects of our dietary in detail and pleaded for systematic and daily use in every household, hand-pounded bran rice, milk-products, (milk, butter, cream and curd), and green leaves and fresh vegetables. He said that it is for the Teachers to teach their pupils lessons of Health as it is only through them the future citizens may be healthy and strong.

Then Dr. Rajarathnam, L M. &. S , B. S. S. C , Municipal Health Officer, Tinnevelly, opened the Health Exhibition and delivered an interesting lecture in Tamil about Sanitation.

The Exhibit consisted of posters on Tuberculosis, small- pox, cholera, flies, Mosquitoes and Malaria. This was very much appreciated by the public particularly by the teachers.

The Exhibition was kept open till late in the evening and was attended by teachers, boys and girls in batches.

## THE MEDICAL PRACTITIONERS' ASSOCIATION, NUZVID.

*The 5th Anniversary Celebration.*

The 5th Anniversary of the above Association was celebrated on Sunday the 12th December 1937 at Nuzvid in the local Government Hospital premises when Captain R. Venkatrao M.B.B.S , Assistant D.M.O. West Godavari presided. After taking a group photo the members were entertained to light refreshments and tea. Several practitioners from distant places attended the function including Dr H. G. Hebard of the local Mission Hospital and Mrs. N. M. C. Seshagiri Rao, a local private practitioner. The meeting commenced exactly by 5 p. m. with prayer and the Secretary Mr. N. Rama Rao read the Annual Report which was duly adopted. Dr. P. Anjaiah Naidu was elected as the President of the Association for the year in place of Dr. D. Satyanarayana and Dr. N. Rama Rao was re-elected as the Secretary.

A paper on 'Infant and its food' was read by Mr. P. Anjaiah and Mr. N. Rama Rao read his paper on 'Female Sex Endo-crinology and also his clinical note on a case of Urticaria Gigans'. Mr. V. Ananthachari read a paper on 'Allergy'. The above subjects gave scope for a wide discussion and the President after thanking the Secretary and the members for the honour done him and congratulating the Association for its activities though small proceeded with his lecture on 'common diseases at the out-patient department' wherein he dealt with fevers. Diarrhoeas and Dysenteries, colds and diseases of Respiratory tracts paralysis, Diabetes, Venereals and Common Surgical conditions. He pointed out several mistakes generally committed both in Diagnosis and treatment of the above diseases and their common complications.

After a vote of thanks proposed by the Secretary to the chair and the members, the meeting ended by 8 P. M.

## THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION, PALAMCOTTAH.

*(Tinnevelly Branch of the Indian Medicat Association).*

The Tinnevelly District Medical Association held its monthly meeting at Srivaikuntam, on Saturday the 18th of December 1937, at 4-30 p.m Members numbering 29 gathered from all parts of the District.

After Tea Party and sweet music on flute the meeting began under the Presidentship of Lieut. Col., T. S. Shastry, I.M.S. The Secretary & Treasurer Dr. K. Rama Ayyar, M.B.B.S., (Andhra), read the minutes of the monthly meeting held at Headquarters on 27-11-1937 which were passed.

The President announced that 17 members of our Association have intimated their intention to attend the All India Medical Conference at Madras, and exhorted that as many members as can possibly do so, should attend the Conference as it is the chance of a lifetime for most members as the social and educative value of such a gathering is enormous.

The following clinical cases were demonstrated :—

Dr. P. S. Srinivasan, showed a case of Myxoedema.

Dr. D. Maduranayagam, L.M.P., of the Local Fund Hospital, Srivaikuntam, read out interesting notes of the following cases :—

1. A case of Pulmonary Stenosis of the heart.
2. A case of Tubercular disease of the elbow joint & finger.
3. A case of Chronic Rheumatic Arthritis.

Thereafter Colonel Shastry, summed up the salient and important features of all the cases and their differential Diagnosis, and offered his thanks to Dr. D. Maduranayagam, Sub Assistant Surgeon of the Local Fund Hospital, Srivaikuntam, for the splendid arrangements and to the school authorities.

Thereafter an excellent Dinner brought the happy gathering to a close late at night.

### HEALTH EXHIBITION.

Under the auspices of the Tinnevelly District Medical Association, in connection with its monthly meeting at Srivaikuntam, a Health Exhibition was arranged at the Coronation High School, Srivaikuntam, on Saturday the 18th of December 1937 at 10 a.m. under the auspices of M. R. Ry. K. N. Kumarakuruparan Pillai Avl., B.A., B.L., of Srivaikuntam.

Dr. D. Maduranayagam, welcomed the gathering and requested M. R. Ry. Kumarakuruparan Pillai Avl., to open the Exhibition.

M. R. Ry. Kumarakuruparan Pillai Avl , in declaring the Exhibition open said that such Exhibitions are very useful, instructive and beneficial to the public and school children and promised to devote his best attention to encourage Health propaganda.

Dr. D. Maduranayagam, explained in Tamil the exhibited posters on the prevention and causation of Tuberculosis, Malaria, Cholera and Flies, for the benefit of about 150 boys, teachers, and public.

This was very much appreciated by the gathering.

## PUNJAB MEDICAL COUNCIL.

Extracts from the Proceedings of a meeting of the Punjab Medical Council held in the Committee room of the office of the Inspector-General of Civil Hospitals, Punjab, Lahore, at 11 a. m., on Saturday the 13th November, 1937.

Before transacting the business it was decided to congratulate K. B. Dr. K. A. Rahman, O. B. E., on his appointment as Secretary Medical Council of India.

K. B. Dr. K. A. Rahman thanked the members for their felicitations.

1. The proceedings of the last general meeting held on the 24th. April 1937, were confirmed.

# CALOGLAND

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2. Considered the following items arising out of the proceedings of the last general meeting :—

(*i*) Inspection Report on the Ludhiana Medical School for Men Decided (*a*) that the clinical material is adequate for the four students who have passed the 3rd Professional Examination held in October, 1937, and therefore recognition be accorded for these students to appear in the Final L. S M. F. Examination in May, 1939.

(*b*) that the additional fixed deposit of Rs. 15,000, recommended by the Inspectors be raised to Rs. 25,000—but that this additional sum be utilized in constructing a hospital before the next inspection.

(*c*) that the school be again inspected not later than February, 1939.

(*ii*) Considered the appointment of members of the Sub-Committee appointed to suggest a revised syllabus for the L. S. M. F. Examination with ways and means for its adoption, specially with reference to :—

(*a*) Pre-medical education.

(*b*) Numbers of years of medical study. Decided that the following members be appointed on the Sub-Committee :—

1. Lt. Col. P. B. Bharucha, O B E, I. M. S.,
2. Major S. M. K. Mallick, I. M. S,
3. R. B. Dr. Maharaj Krishna Kapur.
4. Dr. Gian Chand Blaggana.
5. Dr. E. M. Brown, D. B. E., (co-opted.)

and that the Sub-Committee should function after the deliberations of the meeting of the Principals of Medical Schools to be called by the Director-General, Indian Medical Service.

(*iii*) Punjab Government letter No. 1730-M-37, 22191, dated the 1st June 1937, regarding representation of the Punjab Medical Council on the Punjab State Medical Faculty.

Dr. Vishwa Nath, M. A , M. D., pointed out that the decision of Govt : is based on the adverse opinion expressed by the President when forwarding the resolution of the Council to Government, while he had no authority to do so The President agreed that the action was irregular and hoped it would not occur in future.

3. Items Nos. 3 (*i*) and (*ii*) appearing in the Agendawere disallowed by the President under by-law 8 (*a*).

4. (*i*) Item No. 4 (*i*) appearing in the Agenda was disallowed by the President under by-law 8 (*a*).

(*ii*) Decided that the Government be requested to amend the rules for the compilation and publication of the Punjab Medical Register so that the District-wise index be added to the Annual Medical List.

(*iii*) Decided that in future detailed proceedings of the Punjab Medical Council without the names of the proposers and seconders be sent to the medical press for publication.

(*iv*) Decided that this Council considers it very undesirable that Medical practitioners should make use of prescription forms bearing the name or the advertisement of any individual pharmacist or firm of pharmacists.

Considered the advisability of announcing in newspapers legal action against bogus practitioners as soon as sanction for prosecution is accorded by Government.

Resolved that the newspapers be only notified when a case has been decided by a Court of Law.

Decided that (*i*) the attention of the Principal, Punjab Medical School for Women, Ludhiana, be invited to section 4 (2) of the Punjab Medical Registration Act, that Dr. Rosenberg is not eligible to hold the appointment of Lecturer in the School as she is not registered as a medical practitioner with the Punjab Medical Council.

(*ii*) the attention of the Governing Body of the Punjab State Medical Faculty be drawn to the fact that Dr. Rosenberg not being registered as a Medical practitioner in the Punjab, was a ineligible for appointment as a Lecturer in the Punjab Medical School for Women, Ludhian and consequently she should not be appointed Examiner in the subject of Pathology for the L.S.M.F. Examination.

The Punjab Medical Council placed on record its sincere appreciation of the valuable services rendered by Colonel C. H. Reinhold, M.C ,I.M.S., during the period he held the office of the President of the Punjab Medical Council and it was added that even those who opposed his rulings in this day's meeting appreciated his sincerity of purpose, and that all the members

of the Council joined in wishing him a happy retirement and a joyous and prosperous future for Mrs. Reinhold, and other members of his family. Col. Reinhold thanked the members of the Council.

## APPENDIX.

Proceedings of a meeting of the Registration Sub-Committee of the Punjab Medical Council held in the Committee Room of the Office of the Inspector-General of Civil Hospitals, Punjab, Lahore, on Saturday the 30th October, 1937, at 11 a. m.

Considered the question of removing the name of Dr. Raghu Nath Rai, L.M P., who has been sentenced by a Court of Law in Multan, to undergo six months' rigorous imprisonment plus a fine of Rs. 100.

Recommended that the name of Dr Raghu Nath Rai, L.M P. be removed from the Punjab Medical Register.

Considered the complaint of Dr. Tilak Raj Sethi, Wazirabad, against another registered medical practitioner Dr. Teja Singh.

Recommended that Dr. Teja Singh be asked that the signboard of his compounder Baldev Singh should not be exhibited at his premises along with his own signboard

Considered the request of Dr. Wazir Singh, M.P.L for restoration of his name to the Punjab Medical Register.

Recommended that the name of Dr. Wazir Singh be restored to the Punjab Medical Register subject to a satisfactory report from the Civil Surgeon, Rawalpindi, in regard to Dr. Wazir Singh's character.

Considered the applications of Lady Doctors Mrs. Celzer, M. D. (U. Rome) and Mrs. Kalisch, M. D. (U. Rome), for registration of their names in the Punjab Medical Register.

Recommended that they be asked to show causes for the advertisement published by them recently in the lay press, and also for styling themselves as " registered medical practitioners " and that their explanations be placed before the next meeting of the Registration Sub-Committee.

Considered the explanations of Dr. Selzer and Dr. Kalisch for publishing an advertisement.

Recommended that they be warned that the Punjab Medical Council views with disfavour even indirect resort to advertisement.